Medicaid Expansion Hospital Assessment Act

Sunset Overview

Purpose

Title 26B, Chapter 3, Part 6 establishes the assessment and collection of a fee on both private and government hospitals to offset the cost of Medicaid expansion (i.e. expanded coverage to also cover childless adults and "higher income" parents.)

The Department of Health and Human Services administers the assessment and deposits the proceeds into an expendable special revenue fund known as the Medicaid Expansion Fund, created in 2018. The fund consists of:

- assessments collected under Title 26B, Chapter 3, Part 5, Inpatient Hospital Assessment;
- assessments collected under Title 26B, Chapter 3, Part 6, Medicaid Expansion Hospital Assessment;
- intergovernmental transfers under Section 26B-3-508;
- savings attributable to the health coverage improvement program as determined by the department;
- savings attributable to the enhancement waiver program as determined by the department;
- savings attributable to the Medicaid waiver expansion as determined by the department;
- savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26B-3-105(3) as determined by the department;
- revenues collected from the sales tax under Subsection 59-12-103(11);
- gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;
- interest earned on money in the fund; and
- additional amounts as appropriated by the Legislature.

The Medicaid Expansion Fund can be used to pay the costs, not otherwise paid for with federal funds or revenue sources, of:

- the health coverage improvement program under Section 26B-3-501;
- the enhancement waiver program under Section 26B-3-501;
- a Medicaid waiver expansion under Section 26B-3-501; and
- the outpatient upper payment limit supplemental payments under Section 26B-3-511.

MEDICAID EXPANSION FUND

Fiscal Year	Beginning Balance	Revenues	Expenses	Transfers	Ending Balance
2016	$0.00	$0.00	$0.00	$0.00	$0.00
2017	$0.00	$0.00	$0.00	$735,564.00	$735,564.00
2018	$735,564.00	$5,089,816.00	$0.00	$266,771.00	$6,092,151.00
2019	$6,092,151.00	$30,198,469.00	$0.00	$26,440,161.00	$62,730,781.00
2020	$62,730,781.00	$125,754,448.00	$0.00	($79,168,062.00)	$109,317,167.00
2021	$109,317,167.00	$119,579,335.00	$0.00	($69,976,405.00)	$158,920,097.00
2022	$158,920,097.00	$136,927,753.00	$0.00	($98,004,071.00)	$197,843,779.00

Current Sunset Date

July 1, 2024 (Utah Code Section 63I-1-226)

Sections of Code that Sunset

- Title 26B, Chapter 3, Part 6

26B-3-601. Definitions.

As used in this part:

(1)"Assessment" means the Medicaid expansion hospital assessment established by this part.

(2) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(3) "Discharges" means the number of total hospital discharges reported on:

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

(4) "Division" means the Division of Integrated Healthcare within the department.

(5) "Hospital share" means the hospital share described in Section 26B-3-605.

(6) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26B-3-202.

(7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26B-1-315.

(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26B-3-210.

(9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

(10)

(a) "Non-state government hospital" means a hospital owned by a non-state government entity.

(b) "Non-state government hospital" does not include:

(i) the Utah State Hospital; or

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.

(11)

(a) "Private hospital" means:

(i) a privately owned general acute hospital operating in the state as defined in Section 26B-2-201; or

(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital for which inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment as defined in Section 26B-2-101.

(12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in accordance with Subsection 26B-3-113(5).

(13) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

26B-3-602. Application

(1) Other than for the imposition of the assessment described in this part, nothing in this part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:

(a) state law;

(b) ad valorem property tax requirement;

(c) sales or use tax requirement; or

(d) other requirements imposed by taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.

(2) A hospital paying an assessment under this part may include the assessment as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This part does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon a hospital; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

26B-3-603. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of:

(i) April 1, 2019; and

(ii) CMS approval of the assessment under this part;

(b) in the amount designated in Sections 26B-3-606 and 26B-3-607; and

(c) in accordance with Section 26B-3-604.

(2) The assessment imposed by this part is due and payable in accordance with Subsection 26B-3-604(4).

26B-3-604. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The department shall act as the collecting agent for the assessment imposed under Section 26B-3-603.

(2) The department shall administer and enforce the provisions of this part, and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this part;

(b) audit records of a facility that:

(i) is subject to the assessment imposed under this part; and

(ii) does not file a Medicare cost report; and

(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.

(3) The department shall:

(a) administer the assessment in this part separately from the assessments in Part 7, Hospital Provider Assessment, and Part 5, Inpatient Hospital Assessment; and

(b) deposit assessments collected under this part into the Medicaid Expansion Fund.

(4)

(a) Hospitals shall pay the quarterly assessments imposed by this part to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

(b) The department may make rules creating requirements to allow the time for paying the assessment to be extended.

26B-3-605. Hospital share.

(1) The hospital share is:

(a) for the period from April 1, 2019, through June 30, 2020, $15,000,000; and

(b) beginning July 1, 2020, 100% of the state's net cost of the qualified Medicaid expansion, after deducting appropriate offsets and savings expected as a result of implementing the qualified Medicaid expansion, including:

(i) savings from:

(A) the Primary Care Network program;

(B) the health coverage improvement program, as defined in Section 26B-3-207;

(C) the state portion of inpatient prison medical coverage;

(D) behavioral health coverage; and

(E) county contributions to the non-federal share of Medicaid expenditures; and

(ii) any funds appropriated to the Medicaid Expansion Fund.

(2)

(a) Beginning July 1, 2020, the hospital share is capped at no more than $15,000,000 annually.

(b) Beginning July 1, 2020, the division shall prorate the cap specified in Subsection (2)(a) in any year in which the qualified Medicaid expansion is not in effect for the full fiscal year.

26B-3-606. Hospital financing.

(1) Private hospitals shall be assessed under this part for the portion of the hospital share described in Section 26B-3-611.

(2) In the report described in Subsection 26B-3-113(8), the department shall calculate the state's net cost of the qualified Medicaid expansion.

(3) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the division shall apply the underpayment or overpayment of the assessment by the private hospitals to the fiscal year in which the report is issued.

26B-3-607. Calculation of assessment.

(1)

(a) Except as provided in Subsection (1)(b), each private hospital shall pay an annual assessment due on the last day of each quarter in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and more than 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection 26B-3-606(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this part.

(e) The division shall apply any quarterly changes to the uniform assessment rate uniformly to all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3)

(a) If a hospital's fiscal year Medicare cost report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and

(iii) if the hospital fails to submit discharge information, the division shall audit the hospital's records and may impose a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the division shall calculate the assessment for each hospital separately; and

(b) each separate hospital shall pay the assessment imposed by this part.

(5) If multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

26B-3-608. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) A state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of:

(a) April 1, 2019; or

(b) CMS approval of the assessment for private hospitals in this part.

(3) The intergovernmental transfer is apportioned between the non-state government hospitals as follows:

(a) the state teaching hospital shall pay for the portion of the hospital share described in Section 26B-3-611; and

(b) non-state government hospitals shall pay for the portion of the hospital share described in Section 26B-3-611.

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

26B-3-609. Penalties.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this part, within the time required by this part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.

(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

(i) any unpaid quarterly assessment or intergovernmental transfer; and

(ii) any unpaid penalty assessment.

(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive or reduce any of the penalties imposed under this part.

26B-3-610. Hospital reimbursement.

(1) If the qualified Medicaid expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include in a contract to provide benefits under the qualified Medicaid expansion a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the qualified Medicaid expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits the department or a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

26B-3-611. Hospital financing of the hospital share.

(1) For the first two full fiscal years that the assessment is in effect, the department shall:

(a) assess private hospitals under this part for 69% of the hospital share;

(b) require the state teaching hospital to make an intergovernmental transfer under this part for 30% of the hospital share; and

(c) require non-state government hospitals to make an intergovernmental transfer under this part for 1% of the hospital share.

(2)

(a) At the beginning of the third full fiscal year that the assessment is in effect, and at the beginning of each subsequent fiscal year, the department may set a different percentage share for private hospitals, the state teaching hospital, and non-state government hospitals by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with input from private hospitals and private teaching hospitals.

(b) If the department does not set a different percentage share under Subsection (2)(a), the percentage shares in Subsection (1) shall apply.

26B-3-612. Suspension of assessment.

(1) The department shall suspend the assessment imposed by this part when the executive director certifies that:

(a) action by Congress is in effect that disqualifies the assessment imposed by this part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(b) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this part; or

(c) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015.

(2) If the assessment is suspended under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this part;

(b) the division shall disburse money in the Medicaid Expansion Fund that was derived from assessments imposed by this part in accordance with the requirements in Subsection 26B-1-315(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment; and

(c) the division shall refund any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this part to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years.